STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	10/17/2017

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PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from October 9, 2017 through October 17, 2017. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 144. The stage two survey sample was forty (40). Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; FSD - Food Service Director; RD - Registered Dietitian; FMD - Facility Maintenance Director; OT-occupational therapy/therapist; NP - Nurse Practitioner; PA - Physician Assistant; SW - Social Worker; ADLs (Activities of Daily Living) - such as bathing and dressing; Alzheimer's -type of dementia; Antianxiety - drug to treat anxiety; Antidepressant - drug to treat depression; Antipsychotic - drug to treat psychosis and other mental/emotional conditions (e.g. Risperdal, Seroquel);	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/07/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Anxiety - feeling worried, nervous or restless; Analgesia-inability to feel pain; Ativan-medication used to treat anxiety; Behavior monitoring - documentation of resident behaviors; BID - twice a day; Bilateral - both sides; Bipolar - mood disorder with periods of sadness and excitement; Blood Pressure (BP) - the measure of the force of blood against the walls of a blood vessel; Care Area Summary (CAA) - part of the MDS assessment to identify and plan for problem areas; Carious/Caries- tooth cavities; Cognition - mental abilities, thinking; Cognitively Impaired - mental decline including losing the ability to understand, talk or write; Contracture - joint with fixed resistance to passive stretch of a muscle and cannot straighten; Delusion - false belief that is thought to be true; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation; Dentition - teeth; Depression-sad mood causing impairment in daily life; e.g. - for example; Development disorder -is a group of psychiatric conditions originating in childhood that involve serious impairment in different areas; eMAR - Electronic Medication Administration Record (in the computer); eTAR-Electronic Treatment Record; Fahrenheit (F) - temperature scale; Hallucination - something that seems real but does not really exist; Hyperlipidemia - high cholesterol; Hypertension - high blood pressure;	F 000		

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F 000	Continued From page 2 Hypervigilance - an enhanced state of sensory sensitivity; Hypotension - low blood pressure; HS-hour of sleep; MDS - Minimum Data Set (standardized assessment used in nursing homes); mg (milligrams) - metric measurement of weight; Mood disorder - a psychological disorder characterized by the elevation or lowering of a person's mood, such as depression or bipolar disorder; Mood Stabilizer - drug to prevent mood swings (e.g. Depakote); MP (Metacarpophalangeal) - joints in the fingers and thumb; Neurocognitive disorder - dementia; Palmar - having to do with the palm of the hand; Paranoia/paranoid - extreme fear or distrust of others; PASSR - Preadmission Screening and Resident Review - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; Personality disorder - is a type of mental disorder in which you have a rigid and unhealthy pattern of thinking, functioning and behaving; PRN - As needed; Psychiatrist (Psych) - A physician who specializes in the prevention, diagnosis, and treatment of mental illness; Psychosis - loss of contact/touch with reality; Psychoactive medication - drug used to change brain function to change mood, perception or consciousness; Psychotropic (medication) - medication capable	F 000		

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F 000	Continued From page 3 of affecting the mind, emotions and behavior; q - every; qd-every day; Range of Motion (ROM) - extent to which a joint can be moved safely; Rheumatoid Arthritis - disease causing swollen, painful joints; Schizoaffective disorder - mental disorder with hallucinations or delusions along with a mood disorder such as depression; Schizophrenia - mental disorder with false beliefs, confused thinking and bizarre thoughts; seroquel-medication used to treat mental disorders; Sundowning - change of behavior in late afternoon or early evening; Systolic BP - top number in the blood pressure; TID - three times a day; Tuberculosis - lung disease that spreads easily; Vital signs - clinical measurements (such as pulse rate, temperature, respiration rate, blood pressure); x - times; zyprexa- medication used to treat mental disorders.	F 000		
F 174 SS=E	483.10(g)(6)(7)(i) RIGHT TO TELEPHONE ACCESS WITH PRIVACY (g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. (g)(7) The facility must protect and facilitate that resident's right to communicate with individuals	F 174		12/15/17

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F 174	Continued From page 4 and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide access to the use of a telephone that could be used without being overheard on two (Sierra and Seaside) out of 3 nursing units. Findings include: During the stage 1 interview with R85 on 10/10/17 at 10:25 AM, when asked "Do you have privacy when on the telephone?" the resident responded "No, it is down the hall. We used to have one but it got lost." During the interview the resident expressed that s/he does not get out of bed and did not have a phone at the bedside. 10/10/17 - Observation around 11:00 AM at the Sierra unit nursing station found a wireless telephone base (charger) without a phone on the desk behind a computer monitor. During the stage 1 interview with R87 on 10/9/17 at 12:55 PM it was revealed there was not a private place to use the phone. If R87 needed to use the phone it had to be at the nurse's desk. During an interview with E5 (UM) on 10/12/17 at 10:30 AM E5 confirmed that the portable phone on the Sierra unit was missing and that residents can use a phone in administration or unit manager offices if they need to speak privately. 10/12/17 (around 11:00 AM) Observation on the Seaside unit - Overheard staff down the hallway talking loudly to inform a resident the "battery was	F 174	A. A new cordless phone system was installed on the 2 affected units. Residents R85, R87, R154, and R57 were notified of the new phone system. B. All residents with the desire to make use of a phone have the potential to be affected. All residents on the affected unit will be notified that the new cordless phone system is available for use and how to use the phone with privacy. C. A standard weekly audit order will be placed into REQQER (preventative maintenance program) to ensure the phone available and status is operational. D. An audit will be conducted by the Director of Maintenance or designee to ensure that the new cordless phone system is available and operational at all times. Audits will be conducted daily X4 weeks then weekly X8 or until 100% compliance X3 is achieved. . The audit finding will be reported monthly to the Quality Assurance Committee (QAC) x 3 months.	

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F 174	Continued From page 5 not working" on the wireless phone and the resident would have to "use the phone at the desk" to make calls. 10/13/17 (11:12 AM) Observation at the Sierra unit nursing station - E5 placed the desk phone on the counter for R154 to use. R154 used the telephone with numerous staff and residents in the area. When asked how a resident would have privacy when on the telephone if they were not able to get out of bed, E5 said we "could use our [personal] cell phone." 10/16/17 (around 11:45 AM) Observation - R57 was using the telephone at the Sierra station with numerous residents and staff in the vicinity. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 10/17/17 at 2:00 PM.	F 174		
F 241 SS=E	Surveyor: Armstrong-Kerns, She 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to treat residents with respect and dignity by not knocking and requesting permission to enter the residents' rooms on numerous occasions on two (Sierra and Seaside)	F 241	There are no immediate corrective measures that can be taken for this deficient practice. There was no negative outcome from this deficient practice. B. All residents in the confines of their	12/15/17

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F 241	Continued From page 6 out of 3 nursing units. Findings include: During random observation it was discovered staff entering resident rooms without knocking, asking permission to enter, or verbally announcing self: 1. 10/9/17 Sierra Unit lunch time observation - E13 (CNA): 111, 129, 108, 107 and 110. - E14 (CNA): 119, 115, 106 and 124. - E15 (CNA): 134 and 128. - E16 (CNA): 109. 2. 10/12/17 (7:45 AM) - E25 (LPN) entered room 325 without knocking or verbally announcing self. 3. 10/13/17 (5:24 AM) - E24 (LPN) entered room 127 without knocking or verbally announcing self on 2 occasions. 4. 10/13/17 Sierra unit lunch time observation - E12: 104 and 106 x 2. 5. 10/13/17 Seaside unit lunch time observation - E18 (CNA): 309. - E19 (CNA): 304 and 340 x 2. 6. 10/16/17 Seaside unit lunch time observation - E19 (CNA): 341 x 2. 7. During a stage 1 interview on the Sierra unit with R85 on 10/10/17 around 10:20 AM E12 (LPN) entered the resident's room and walked around the curtain, which was pulled to provide privacy, without knocking or verbally announcing self. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on	F 241	room that require staff interaction have the potential to be affected by this deficient practice. Immediate notifications were displayed on the facility teleprompter's as a visual reminder to knock prior to entry. C. All staff will be provided education by the staff development nurse or designee on respect and dignity per facility policy and procedures including the appropriate protocol prior to entering a resident's room that includes knocking, announcing self and resident response as appropriate. D. Observational audits will be conducted by the Ambassadors or designee weekly x4 then monthly X2 until 100% compliance is achieved X3. The audit findings will be reported to the QAC monthly X 3.	

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F 241	Continued From page 7 10/17/17 at 2:00 PM.	F 241		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to honor the resident's preference for frequency of bathing on one (Sierra unit) out of 3 nursing units and the type of bath for one (R120) out of 40 sampled residents. Findings include: 1. During the stage 1 interview with R120 on 10/9/17 at 1:23 PM when asked, "Do you choose how many times a week you take a bath or shower?" the resident said, "No, it depends on the aide... if they have the time." R120 added that his/her shower had been scheduled on Wednesday and Saturday evenings (after dinner) but sometimes they do a bedbath instead. 10/12/17 - Review of R120's clinical record	F 242	A. R120 was interviewed to determine bathing preferences. R120's care plan was updated and revised to reflect R120's bathing choices. B. An interview process was completed with all residents and or their resident representative to determine bathing preferences including day(s), type and time. Those residents identified with changes in preferences had their care plans revised. C. An interview subsequent to admission will be conducted by the Activities staff or designee to determine resident bathing preferences. This information will be communicated to the nursing staff for care planning and scheduling.	12/15/17

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F 242	Continued From page 8 revealed: July, 2017 - October, 2017 - Review of R120's CNA documentation for bathing found 6 occasions when R120 was scheduled for a shower (or tub bath) but a bedbath was provided instead: August 5, 23; September 9, 16, 30; and October 7. During an interview with E5 (UM) on 10/12/17 around 2:50 PM E5 confirmed the findings. 2. During an interview with E5 (UM) on 10/11/17 at 11:28 AM when discussing the process for scheduling showers, E5 said that the schedule "falls by room number...then if they want more we will add it." The facility relied on the resident and family to request more showers versus determining the resident preference. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 10/17/17 at 2:00 PM.	F 242	D. An audit will be conducted weekly X 4 then monthly X2 by the QA nurse or designee until 100% compliance is achieved X3. The audit findings will be reported to the QAC monthly X3.	
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.	F 244		12/15/17

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F 244	Continued From page 9 (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to act promptly on resident council concerns for the past six months of council minutes reviewed. Findings include: During the resident council interview on 10/10/17 around 9:35 AM when asked "Does the facility staff respond to the resident's/group's concerns?" R100 (Resident Council President) stated "Sometimes, but I keep on them until something is done." The outstanding topic of concern, according to R100, was "call lights being answered. They just tell us staff was educated." Review of resident council minutes for the previous 6 months revealed the following recurring concerns: - Not answering call lights timely: April, August and September. - Not knocking when entering resident room: May and June; multiple observations during survey. - Requesting sports packages on TV: April through September. During an interview with E10 (Staff Development) on 10/11/17 at 12:46 PM E10 presented the sign in sheets from inservices performed in response to resident council concerns. E10 added that there was no education in June since E10 started in staff development in middle of June. During an interview with E9 (Activity Director) on 10/11/17 at 12:48 PM to discuss the lack of	F 244	A. There are no immediate corrective measures that can be taken for this deficient practice. The resident council minutes for the past 6 month were reviewed with R100. The existing concerns were discussed and a plan of resolution was developed. B. All residents have the potential to be affected by this deficient practice. Ambassador's interviewed their assigned residents regarding answering call bells timely and knocking on doors protocol. Any negative findings were addressed immediately. C. Residents have been informed and encouraged to utilize the individual grievance process related to timely call bell response and lack of knocking on doors. The minutes of the monthly resident council meetings will be reviewed by the Activities Director or designee for monthly trends. Any duplicate concerns from the previous month will be followed upon until resolved and approved at the next resident council meeting. D. Trends/Concerns audits will be completed monthly x12 by the activities director or designee to ensure compliance. The audit findings will be reported to the QAC monthly X12 months.	

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F 244	Continued From page 10 resolution or comment regarding the sports channel E9 stated that "corporate said if it shows up for more than 5 times, they would consider it." During an interview with E2 (DON) on 10/16/17 at 2:20 PM to request evidence of education in response to the June resident council meeting, E2 said s/he would see "if I have something that I put away." The surveyor commented that education had been completed several times for call light answering and knocking and asked what was the next step, to which E2 stated it was "an ongoing problem" and would like a call light system that tells response times. In regard to the lack of resolution regarding the sports channel request and E9's comment about when corporate would look into it, E2 was not sure if the resident council was aware. During a follow-up interview with E9 and E10 on 10/16/17 at 2:45 PM E10 provided a copy of training from the end of June about resident council concerns from that month along with sign in sheets covering multiple topics performed in July. E9 stated that s/he did not include a resolution (or comment) in the council minutes since it was not totally resolved. The facility did not take action beyond education to address resident council concerns of knocking on doors and timely call light response. During an interview with E2 on 10/17/17 at 9:15 AM to review evidence of education received the day before addressing the June council concerns. E2 said "I wish we were able to have the monitoring capability with the call light system" and described the inability to determine exact response time. E2 added that E9 said the same	F 244		

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F 244	Continued From page 11 residents often attend the meetings with the same complaints and thought s/he would start to meet individually with those residents. E2 believes the perception of time lapse may be that residents might think 5 minutes is 20 minutes and aides might think 20 minutes is 5 minutes. When asked if visual audits were completed, E2 said E1 (NHA) would have those. During an interview with E1 on 10/17/17 at 9:40 AM to review audits about answering call lights, E1 produced a binder containing completed Ambassador Round sheets which were "done daily." When thumbing through the completed sheets E1 said they "are done almost daily." When asked what shifts the ambassadors work E1 stated that ambassadors work Monday through Friday and the weekend manager on duty had a different sheet. After retrieving the weekend binder containing completed manager checklists, E1 reviewed the pages and said the newer ones were "in the back." The date on the completed sheet in the back of the book was from November 2016. E1 added that the facility had done audits in the past but that "was for the survey process." Review of both checklists found nothing about call light answering times or knocking on either checklist. These findings were reviewed with E1, E2 and E3 (ADON) at the exit conference on 10/17/17 at 2:00 PM.	F 244		
F 257 SS=E	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81	F 257		12/15/17

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F 257	Continued From page 12 degrees F. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to maintain comfortable temperatures for 2 out of 3 units. Findings include: During general observations in the facility the following was noted: 10/10/17 10:45 AM - During stage one interview R239 answered "it's kinda cold" when asked about comfortable temperatures. 10/11/17 7:39 AM - During observation in the Seaside dayroom R22 was wearing a turtleneck, sweatshirt and covered with a blanket calling out that she was cold. Cool air could be felt blowing from a ceiling vents. Another unidentified resident was also complaining of being cold and a passing housekeeper provided a blanket from her room. 10/13/17 5:55 AM - R99 was in the hallway on Seaside near the therapy room with complaints of being cold. Area did feel cool. 10/13/17 6:26 AM - Temperatures taken in the following areas revealed: Lobby 68.6 F Connecting hall between Sierra and Seaside 70.2 F and 70.0 F Seaside lounge 69.0F, 68.8 F, and 68.6 F Seaside nurse's station 69.5 F Seaside dining room 69.3 F 10/16/17 10:46 AM - Temperatures taken in the following areas revealed: Lobby 69.5 F, 70.0 F, and 68.9 F	F 257	A. The thermostats to the heating units were turn up to increase the low temperatures identified in the affected areas. R22 and R99's resident representatives were informed of this action. B. Any resident expressing concerns regarding cold temperatures, temperatures will be taken in that area and immediately adjusted if outside the parameters of 71-81 F. C. Two new HVAC units have been installed that will supplement the affected areas with low temperatures. Temperatures are within the required 71-81 degrees Fahrenheit. D. Random location temperature audits will be completed daily by the Director of Maintenance or designee for 1 week and then weekly X12 and until 100% compliance is achieved X3. The audit findings will be reported to the QAC monthly x3.	

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	085020	A. BUILDING _____ B. WING _____	10/17/2017

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F 257	Continued From page 13 Seaside dayroom 69.5 F, 69.1 F, and 68.9 F Seaside small dayroom 69.3 F and 68.9 F 10/17/17 at 1:00 PM - hallway outside NHA office 69.2 F These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 10/17/17 at 2:00 PM.	F 257		
F 258 SS=E	483.10(i)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS (i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to maintain comfortable sound levels in 2 out of 3 units. Findings include: The following observations were made during the survey: 1. Meal Cart(s) 10/09/17 11:48 AM - One of three meal carts on Aspen during meal observation was making a very noisy rattling and squeaking sound. E28 (CNA) one of the staff in the area commented "that should wake everyone up". The cart went up and down the hall several times while trays were delivered. 10/16/17 12:49 PM - Food cart wheel making a very loud noise on Seaside 10/17/17 12:30 PM - Food cart wheel very loud	F 258	There are no corrective measures that can be taken for this deficient practice. There was no negative outcome to any resident by this deficient practice. B. Resident satisfaction surveys are completed for each resident upon admission and quarterly thereafter. No residents or their representatives have expressed concerns regarding noise indicated in the identified deficient practice. Ambassadors round daily and report and complaints of excessive noise levels. C. A wheel audit was completed on all the food carts. Any cart wheels that were defective were replaced. The door alarm has be extended from a 10 second alert to a 2 minute alert to allow supervised residents to move in and out of the facility freely without the alarm sounding. D. Random observation audits will be completed by the Director of Maintenance	12/15/17

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F 258	Continued From page 14 noise on Seaside 2. Door Alarms 10/9/17 9:00 AM - During initial tour of the facility it was noted that each time the exterior door was opened in the Seaside lounge a loud screeching alarm goes off and does not stop until the door is closed again. 10/10/17 1:00 PM - At the start of the resident smoke break it was noted that each time the exterior door was opened in the Seaside lounge a loud screeching alarm goes off and does not stop until the door is closed again. The sound could be heard in day area and down nearby hallways. 10/13/17 9:00 AM - Same observation of loud screeching alarm as residents went out to smoke. 10/13/17 9:05 AM - During an interview, E3 (ADON) revealed that the alarm goes off anytime the door is opened. When asked if it could be turned off while residents are going out to smoke and turned back on, she said they cannot do that. In the past staff would put something in the door to hold it open and keep the alarm off but then it would not get turned back on and would be a problem if a resident were to get out. 10/16/17 1:00 PM - door alarm off of Seaside lounge makes shrill sound as staff let residents out to smoke and then again as they helped the residents inside 10/17/17 1:00 M - door alarm off of Seaside lounge makes shrill sound as staff let residents out to smoke and then again as they helped the residents inside.	F 258	or designee weekly x 4 then monthly x 2 and 100% compliance achieved x 3. The audit findings will be reported to the QAC monthly X 3.	

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F 258	Continued From page 15 It would be helpful if the facility could find a method to monitor resident safety in the area while decreasing the noise level. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 10/17/17 at 2:00 PM.	F 258		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS (c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R10) out of 39 sampled residents the facility failed to ensure quarterly assessments were completed as scheduled. Findings include: The following was reviewed in R10's clinical record: 8/24/17 - Assessment reference date for quarterly MDS assessment. 10/13/17 - Review of the EMR noted the 8/24/17 was "in progress" and not completed. 10/13/17 11:53 AM - Interview with E29 (RNAC) revealed that one RNAC was out on extended leave and the other RNAC position was vacant at present. This resulted in the facility getting behind in MDS assessments. As a matter of priority	F 276	A. Resident R10's assessment has been completed and submitted. B. An audit was completed of all MDS assessments. Any assessments identified as not completed were completed and submitted. C. The MDS coordinators or designee will review the Point Click Care dashboard daily for any quarterly assessments that are due. Assessments will be completed within the scheduled timeframe. D. Weekly audits x 4 will be performed by the MDS coordinators or designee to identify any assessments that are due within a 2 week window. Audits will continue for an additional 2 months until 100% compliance is achieved x 3. The audit findings will be reported to the QAC monthly X 3.	12/15/17

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F 276	Continued From page 16 admission, Medicare and annual MDS assessments were being completed before the quarterlies. E29 added that if a quarterly MDS appeared to be a significant change in status it would be made a higher priority. It was further revealed that the facility was late on other quarterly assessments that staff hoped to complete this weekend. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 10/17/17 at 2:00 PM.	F 276		
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 279		12/15/17

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F 279	Continued From page 17 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to develop a comprehensive care plan for identified resident	F 279	A. Resident's R85, R22, R169 and R173 care plans were revised to include the identified resident needs with measurable	

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F 279	Continued From page 18 needs and measurable goals for four (R85 and R22, R169, and R173) out of 39 sampled residents. Findings include: 1. Review of R85's clinical record revealed: 5/18/17 - Annual MDS assessment documented R85 had obvious or likely cavity or broken natural teeth. The CAA associated with this assessment identified dental concerns were new and a dental care plan would be developed. Review of the care plan found no problem or interventions in relation to R85's dental concerns. During an interview with E5 (UM) on 10/13/17 around 10:00 AM the surveyor inquired about the location of the dental care plan. During an interview with E3 (ADON) on 10/16/17 on the dental care plan, E3 stated s/he added one on 10/13/17. 2. Review of R22's care plan revealed: 8/24/15 - Care plan included a problem for risk for adverse effects related to use of antianxiety, antipsychotic and antidepressant medication. 8/28/17 - Readmission to the facility with admission orders including a mood stabilizer medication for mood disorder along with an antidepressant. During an interview with E5 (UM) on 10/12/17 at 2:47 PM, E5 confirmed the care plan problem for risk for adverse effects failed to identify the mood stabilizer.	F 279	goals. B. A 20% random care plan audit will be completed by the MDS coordinators or designees of the current census to ensure that all resident needs are care planned, resident specific and measureable. An additional 20% will be selected until 100% compliance is achieved. Those care plans identified as non-compliant were revised immediately. C. All new admission comprehensive assessments will be reviewed for CAA triggers. All new physician orders will be reviewed daily and care planned accordingly with resident specific and measurable goals. Resident specific needs will be reviewed quarterly at their individualized care plan meetings. Identified needs will be care planned at that time. D. A 10% random care plan audit will conducted monthly x 3 by the MDS Coordinators or designee and until 100% compliance is achieved x 3. The audit findings will be reported to QAC monthly x 3.	

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F 279	Continued From page 19 3. The following was reviewed in R173's clinical record: 10/21/16 - Care plan for at risk for changes in mood related to depression, psychosis and anxiety with a goal of will accept care and medication as prescribed. The goal was not specific to the problem and it was not measurable. 10/26/16 - Care plan for Agitation (combative towards staff) related to dementia with a goal of will not harm self or others during agitation period. Approaches included: -observe for increase in behavior frequency (intensity or if behavior is interfering with ADLs, eating or safety of patient or others and notify physician prn. The care plan goal is not specific to the resident's agitation and is not measurable. 4. The following was reviewed in F169's clinical record: 5/24/17 - Care plan for ADL self care deficit as evidenced by visual impairment, cognitive impairment, decreased mobility was a goal of will not develop any complications related to decreased mobility. The goal is not specific to the identified need and is not measurable. These findings were reviewed with E1 (NHA), E2 (DON) and E3 at the exit conference on 10/17/17 at 2:00 PM.	F 279		

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F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280		12/15/17

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F 280	Continued From page 21 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 280		

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F 280	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to revise the care plan for three (R169, R173 and R85) out of 40 sampled residents to reflect the residents' current status. Findings include: 1. The following was reviewed in R169's clinical record: a. 5/24/17 - Care plan for ADL self care deficit as evidenced by visual impairment, cognitive impairment, decreased mobility documented assist with.... eating as needed. 5/24/17 - Care plan for Potential/Alteration in nutritional status related to need for therapeutic diet secondary to cardiac diagnosis with no approached related to level of assistance with eating. 6/20/17 - 30 day MDS documents supervision with eating. 8/30/17 - quarterly MDS documents extensive assistance with eating. 10/11/17 2:28 PM - Interview with E27 (CNA) revealed R169 needs to be fed by staff. b. 7/25/17 - Order for risperdal (antipsychotic) 0.5 mg bid for delusions. Review of the care plan did not address delusions and the behaviors associated with delusions. 2. The following was reviewed in R173's clinical record:	F 280	A. Resident R169's care plan was revised to include assistance with meals and include diagnosis of delusional behavior and associated behaviors. R173's care plan was revised to include delusional disorder. R85's care plan was revised to include the hand splint. B. A 20% random care plan audit will be completed by the DON or designees of the current census to ensure that all resident's current status is addressed. An additional 20% will be selected until 100% compliance is achieved. Those care plans identified as non-compliant were revised immediately. C. All new orders will be reviewed daily by the unit managers or designees and care plans will be updated daily accordingly. The MDS coordinators or designee will report any change in condition (decline or improvement) at the daily morning meeting and care plans will be updated as needed by the unit managers. D. A 10% random care plan audit will conducted monthly x 3 by the DON or designee and until 100% compliance is achieved x 3. The audit findings will be reported to QAC monthly x 3.	

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F 280	Continued From page 23 10/21/16 - Care plan at risk for changes in mood related to depression, psychosis and anxiety will accept care and medication as prescribed. 10/26/16 - Care plan for Agitation (combative towards staff) related to dementia. October 2017 - Review of the MAR revealed that R173 was on an anxiety medication daily for anxiety disorder and an anti-psychotic medication for delusional disorder daily. A second antipsychotic medication for delusion disorder was discontinued on 10/9/17. The care plan did not address delusions that R173 was diagnosed as having and being treated with two different medications. 10/12/17 2:21 PM - Interview with E6 (UM) revealed no further information about the lack of care planning for delusions. 3. Review of R85's clinical record revealed: 9/15/13 - Admission to facility with multiple diagnoses including rheumatoid arthritis. 3/22/14 - Care plan problem (last reviewed 8/18/17) for risk for loss of ROM related to physical limitations / decreased mobility, contractures of bilateral shoulders, wrists, hands, hips, knees and ankles. Interventions included: active assisted ROM twice a day; Report changes in ROM and OT evaluation and treatment as ordered. 8/28/17 - OT note about referral to therapy for right hand contracture. Resident non-compliant with hand ROM and was appropriate for a hand splint.	F 280		

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F 280	Continued From page 24 9/29/17 - OT Recertification Progress Report & Updated Treatment Plan included the short term goal to achieve normal anatomical alignment of right fingers for 1 hour using a palmar [palm of the hand] guard with finger separators. Currently resident tolerating less than 30 minutes. 10/3/17 - Physicians' orders included right hand rheumatoid arthritis palm guard for MP realignment of 2nd and 3rd fingers and skin protection, and hygiene of 4th and 5th digits to be worn as tolerated. Remove every shift, during meals and care for skin check for signs of redness, swelling or skin irritation. Observation on 10/12/17 around 11:30 AM of OT at R85's bedside. E23 (OT) said s/he was making a second splint for when the first one was getting cleaned. During an interview with E5 on 10/12/17 around 2:30 PM E5 confirmed the ROM care plan was not revised to include use of the right hand palm guard with finger separators even though the intervention was added to the eTAR. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 10/17/17 at 2:00 PM.	F 280		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug	F 329		12/15/17

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F 329	Continued From page 25 therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs: Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for four (R169, R173, R22 and R92) out of 40 sampled residents the facility failed to ensure the indications for use and/or monitoring of psychoactive and blood pressure medications. Findings include:	F 329	A. (1) R169's behavior monitoring sheet for paranoia, delusions and exit seeking behavior was initiated. R169's care plan for delusions and paranoia was initiated. (2) R173's indication for use of antipsychotic was clarified. R173's	

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F 329	Continued From page 26 1. The following was reviewed in R169's clinical record: 5/23/17 - Admitted to the facility. 5/23 - 6/27/17 - Review of progress notes documented 6 nurses notes describing yelling, screaming, cussing or verbal outbursts 5/30/17 - Admission MDS indicated no behaviors and no psychiatric or mood disorder. 6/12/17 - Psychiatrist note ...She was somewhat loud and showing some hypervigilance and she was a little bit aggressive. She has been cursing for no obvious reason, but she is not aggressive... 6/26/17 - Psychiatrist note...Alert and oriented to self. The patient is seen for increased agitation, "help me, help me", continuous confusion and disoriented. When patient tried to contact, she repeatedly asked the writer and writer introduced and she said "he is a liar". So she is showing some ongoing paranoia, irritability and not able to understand her need, not able to express herself...she is continuously talks help me and this is secondary to progressive dementia...she denied any aggression or agitation. 6/27/17 - 8/21/17 - Order for depakote DR 125 mg tid for mood disorder. June 27 - 30, 2017 - Behavior monitoring for yelling and cursing, 14 occurrences all on 3-11 shift. 7/24/17 - Psychiatrist note...mood anxious and affect constricted...The patient is not showing any	F 329	behavior monitoring sheet was initiated to monitor target behavior for antipsychotic medication use. R173's behavior monitoring sheet was initiated to monitor target behavior for anti-anxiety use. R173 additionally had an antipsychotic care plan initiated. (3) R22's behavior monitoring sheet for anti-anxiety use was initiated. R22's side effect monitoring sheet was discontinued. (3) R22's order for anti-hypertensive medication was previously corrected prior to survey on 8/18/17. Medication Administration Record (MAR) reflect Blood Pressure (BP) readings prior to administration of medication. (4) R92's behavior monitoring sheet was initiated to monitor target behavior for antipsychotic medication use. (4) R92's MAR was reviewed and nurses involved will be educated regarding BP parameter for Midodrine use. B. (1) All residents receiving antipsychotic medications will be audited to ensure a behavior monitoring sheet is in place to monitor target behaviors for medication use and a care plan is in place addressing target behaviors. (2) All residents receiving antipsychotic medications will be audited to ensure compliance with appropriate indication for medication use and a behavior monitoring sheet is in place to monitor target behaviors. (3) All residents receiving anti-anxiety medications will be audited to ensure a behavior monitoring sheet is available to track target behavior for medication use. All residents receiving Depakote will be reviewed and side	

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F 329	Continued From page 27 delusion or paranoia. No behavior observed, otherwise the patient is compliant with care...The patient is loud and demanding and talking to herself continuously...Plan: will add risperdal 0.5 mg at 2'oclock because she has more sundowning... 7/25/17 - Order for risperdal (antipsychotic) 0.5 mg bid for delusions. R169 was started on an antipsychotic medication, risperdal for delusions after an assessment by the psychiatrist lacked delusions and the clinical record showed no documentation of delusions. July, 2017 - Behavior monitoring for yelling and cursing, 96 occurrences. 8/21/17 - Psychiatrist note...The patient is still acting out, still loud. She is disturbing others, does not follow commands. She has exit seeking behavior, paranoid, delusional and irritable. The patient is not able to follow direction. The patient is loud and disturbs others. Memory is impaired...Plan: no changes at this time. The facility had no documentation of delusions, paranoia or exit seeking behavior. 8/21/17 - 10/9/17 - Order for depakote ER 250 mg BID for mood disorder. 8/30/17 - Quarterly MDS documented physically abusive, verbally abusive, behavior not directed towards other and rejects care each 1 - 3 days of the 7 day review period and no psychiatric or mood disorder. August, 2017 - Behavior monitoring for yelling	F 329	effects sheets discontinued. All residents receiving BP medications with specified parameter will be reviewed to ensure appropriate monitoring and documentation is in place. C. (1) Nursing staff will be in-serviced by Staff Development (SD) RN or designee on behavior monitoring sheets to track behaviors for anti-psychotic medication use, initiation of care plan addressing target behavior for antipsychotic medication use, on behavior monitoring sheets to track behaviors for anti-anxiety medication use. (2) Licensed staff will be in-serviced by SD or designee on appropriate indication of anti-psychotic medication use, regarding appropriate monitoring for Depakote use, on appropriate monitoring and documentation on residents receiving BP medications including BP parameters and Midodrine. D. (1) Audits will be completed for all new admissions and new orders receiving antipsychotic medications, anti-anxiolytic's, Depakote, and BP medications weekly x 1 month then monthly x 2 and 100% compliance is achieved x3. The audit findings will be reported to the QAC monthly X 3.	

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F 329	Continued From page 28 and cursing 170 occurrences; mood change (for risperdal) with 5 occurrences. 9/25/17 - Psychiatrist note..When talking she is not screaming, somewhat she becomes quiet and by herself she starts screaming. It seems that she might have some anxiety being alone. She is not showing any anger but she is nonstop talking and making different noise and gesture...We will add ativan 0.5 mg prn for anxiety. 9/25/17 - 10/9/17 - Order for ativan 0.5 mg q 6 prn anxiety, used 6 times with all doses listed as effective. September, 2017 - Behavior monitoring for yelling and cursing 99 occurrences; mood change 15 occurrences; delusions replaced mood change 9/25/17 with 0 occurrences. 10/10/17 - Order for ativan 0.5 mg qd for anxiety. 10/10/17 - Depakote ER 500 mg hs for mood disorder. October 1-16, 2017 - Behavior monitoring for yelling and cursing 13 occurrences; delusions 0; and restlessness added on 10/9/17 with 0 occurrences. Review of the record lacked a care plan addressing delusions or paranoia. 10/17/17 9:37 AM- Interview with E2 (DON) and E3 (ADON) revealed R169 was admitted with constant screaming. The psychiatrist was working closely with her and the facility was trying to rule out infections. It was hard to figure out why she was screaming. It was revealed that behaviors	F 329		

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F 329	Continued From page 29 would not be monitored in a formal format (using a monitoring sheet) until medication was started instead staff would document behaviors in the progress notes. R169 exhibits behaviors in and out of the room, you can sit with her and she will calm down but it will not last long before she yells and throws things. The resident was described as being unable to communicate for assessment purposes and uses the "F" word. It was revealed that R169 upsets other residents and you can't have her out there bothering others. E3 stated that the psychiatrist told her he had good results using the depakote as a mood stabilizer and the risperdal for the delusional disorder. E3 believes the resident is improving but admitted the medications have not fixed the behaviors. E3 could not describe how the resident exhibits delusions and paranoia. When asked how behavior monitoring data is shared with the psychiatrist it was revealed that there was a sheet that the behaviors numbers were put on for the doctor but it has not been is use. At present the ADON, the unit manager or the nurses talk to the doctor and he can hear the resident. 10/17/17 10:55 AM - Interview with E11 (psychiatrist) when asked about the initiation and increase in psychoactive medication it was revealed that R169 was "talking talking talking", alert and oriented at times with confusion calling out "help me help me" which he thought might be an internal stimuli behavior. E11 stated R169 was started on risperdal, he did not want to increase the dose so he added depakote because it will at times work well with risperdal. E11 made increases in dosage to the depakote and then added ativan. E11 stated that a little improvement has been seen, the behaviors are ongoing but not so aggressive. When asked how the behaviors	F 329		

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F 329	Continued From page 30 between his consult visits are reviewed it was revealed E11 knows her well because of her constant noise, he talks to the CNA who takes care of her and the supervisor, staff tell him what is going on. When asked how staff would monitor for mood changes and delusions it was revealed that the resident is paranoid about people talking about her, so (she) had some delusional thinking. E11 further revealed that we (physicians) have limitations with Medicare list of diagnoses (for the use of these medications) so this is the practice we are using (for R169). Review of record lacked documentation of paranoia. It was unclear in the interview with E11 how delusional behavior was being assessed for the use of antipsychotic medication. R169 was ordered and administered mood stabilizing and antipsychotic medications without appropriate indications for use and monitoring. 2. The following was reviewed in R173's clinical record: 10/19/16 - Admitted to the facility. 10/21/16 - Care plan for at risk for changes in mood related to depression, psychosis and anxiety. Interventions included: Administer medication per physician orders and observe for and report any side effects; Assess for physical/environmental changes that may precipitate change in mood; Monitor for and report any decline in ADL ability or mood; Observe for and report any changes in mood; Observe for mental status/mood state changes when new medication is started or with dose changes.	F 329		

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F 329	Continued From page 31 10/26/16 - Care plan for agitation (combative towards staff) related to dementia. Interventions included: Observe for increase in behavior frequency, intensity or if behavior is interfering with ADLs, eating or safety of patient or others and notify physician prn; Administer medication per physician orders and monitor effectiveness; Observe for side effects and notify physician as needed; Observe for and report any decline in ADL ability or behavior and Psych consult. 10/26/16 - Admission MDS does not indicate resident has a psychotic disorder. 12/13/16 - 1/4/17 - Admission to psychiatric facility. Admission assessment documented: anxiety and depression with agitation...pt has been increasingly agitated, aggressive wandering non compliant, confused given zyprexa and cymbalta (anti-depressant) without improvement, pt is paranoid about staff at facility. Discharge summary documented medication changes, less agitated, eating and sleeping better major depressive episode severe recurrent with psych major neurocognitive disorder [previously known as dementia]; personality disorder, development disorder. 1/18/17 - Quarterly MDS does not indicate a psychotic disorder. Psychiatrist Visits list the following mental health issues: 1/23/17 - Dementia Alzheimer's type, mood disorder, major depression 2/6/17 - Dementia in other condition with behavioral disturbance and mood disorder 3/3/17 - Dementia Alzheimer's type and major depression	F 329		

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F 329	Continued From page 32 5/1/17 - Dementia in other condition classified elsewhere with behavioral disturbances mood disorder and generalized anxiety disorder 6/19/17 Dementia Alzheimer's type, major depression...admitted since October 2016 with history of delusion disorder, dementia with behavioral disturbances, anxiety disorder...major depression 8/21/17 Dementia other and behavioral disorder...will discontinue Ativan for non-use 9/25/17 Dementia Alzheimer's type and generalized anxiety It was not clear whether the resident had dementia of the Alzheimer's type or another form of dementia. There was no description of the delusional disorder. August 2017 TAR -Behavior monitoring for restlessness that was discontinued on 8/26/17 when an as needed dose of Ativan was also discontinued. -Behavior monitoring for hitting and striking. September TAR -Behavior monitoring for hitting and striking. October TAR -Behavior monitoring for hitting and striking. October MAR -Anti-psychotic medication (Seroquel) daily at bedtime for delusional disorder ordered 1/4/17 and discontinued 10/9/17. -Anti-anxiety medication (Ativan) daily at bedtime for anxiety disorder ordered 1/4/17. -Anti-psychotic medication (Zyprexa) daily for delusional disorder ordered 1/5/17.	F 329		

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F 329	Continued From page 33 There was no evidence that the behaviors associated with delusions requiring the use of anti-psychotic medications were ever identified and monitored for. There was no evidence that the behaviors for anxiety were monitored after 8/26/17. 10/12/17 2:21 PM Interview with E6 (UM) about behavioral monitoring and delusional disorder revealed R173 says things like "did you see that man come in here he was just talking to me" and sees and talks about things that did not happen. E6 did not believe paranoia was a problem for this resident. It was further revealed that the resident presents anxiety with restlessness and responding inappropriately by crying if she doesn't get her juice first. E6 believes that at one time staff were monitoring anxiety but it must have fallen off the charting. R173 was administered anti-psychotic medication in the absence of identifying the behaviors associated with the delusional disorder to ensure adequate indication of use and failing to monitor the behaviors associated with the medication usage. 2016 - Lippincott's Nursing Drug Handbook listed the 8 rights of medication administration as follows: 1. Right patient, 2. Right medication, 3. Right dose, 4. Right route, 5. Right time, 6. Right documentation, 7. Right reason, and 8. Right response. (Reference: Nursing 2016 Drug Handbook. (2016). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania.)	F 329		

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F 329	Continued From page 34 Facility policy entitled Administering Medications (revised December, 2012) included that as required or indicated for a medication, the individual administering the medication will record in the resident's medical record any complaints or symptoms for which the drug was administered; any results achieved and when those results were observed. 3. Review of R22's clinical record revealed: Current care plan contained the following problems and interventions: - 7/10/13: Anxiety related to loss of control, cognitive impairment and visual impairment included the intervention to give medication per orders and observe for effect. - 6/24/14: Hypertension included the interventions to administer medication as per MD orders and observe for effectiveness: record vital signs as clinically indicated; report changes to physician. - 11/24/14: Verbal/physical aggression (yelling, cursing, hitting at staff and/or residents) related to cognitive impairment, disease process, dementia with interventions including to administer medication per physician order and monitor for effectiveness and observe for side effects; observe for increases in behavior frequency/intensity. - 8/24/15: Risk for adverse effects related to use of antianxiety, antipsychotic, and antidepressant medication included the intervention to evaluate effectiveness and side effects of medications for possible decrease/elimination of phsychotropic drugs. - 11/10/15: Risk for changes in mood related to diagnosis of mood disorder, dementia . . .history of tobacco and alcohol abuse included the	F 329		

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F 329	Continued From page 35 intervention to administer medication per physician orders and observe for and report any side effects. a. Psychotropic Medications 8/28/17 - Readmission physicians' orders after hospitalization included a mood stabilizer to be given twice a day. 9/17/17 - Physicians orders included a PRN medication for anxiety. June, 2017 - October, 2017 - Review of eMARs and nursing notes discovered: - R22 received 13 PRN administrations of a medication to treat anxiety that did not include an assessment of specific resident behaviors prior to 5 doses of medication (September 18, 21, 22 and 28; October 7). - Monitoring for side effect of antipsychotic listed the mood stabilizer medication which is not an antipsychotic. During an interview with E6 (UM) on 10/12/17 at 2:47 PM E6 confirmed that the care plan for adverse effects was missing the mood stabilizer and that the drug was not an antipsychotic as indicated on the side effect monitoring. During an interview on 10/12/17 at 2:54 E6 confirmed the missing behavior assessments. b. Blood Pressure Medications 8/28/17 - Readmission physicians' orders after hospitalization included a medication for high blood pressure to be given daily unless systolic BP was under 100.	F 329		

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F 329	Continued From page 36 February, 2017 - October, 2017 - Review of eMAR, vital signs and nursing notes found no evidence of a blood pressure assessment at the time of the medication (scheduled to be given at 8:00 AM) for hypertension to determine if it needed to be held. R22's blood pressure was taken weekly on evening shift. There was no space designated on the eMARs to document the blood pressure until 8/18/17. R22's BP was low and the medication was not administered on 8/31/17. R22 was administered a medication for hypertension for 6 and a half months without BP assessment for this medication with a BP parameter. During an interview with E6 on 10/12/17 around 2:45 PM confirmed this medication had a BP parameter and the blood pressures were not written on the eMAR. E6 added that it was "up to the nurse to take it" [blood pressure] and "give if ok." 4. Review of R92's clinical record revealed: 6/1/16 - Care plan problems and interventions: - At risk for changes in behavior problems related to paranoid schizophrenia with hallucinations/delusions, bipolar schizoaffective disorder included intervention to administer medications per physician order; observe for changes in behavior/side effects; evaluate effectiveness and side effects of medications for possible; observe for mental status/behavior changes when new medication started or with changes in dosage. - At risk for changes in mood related to	F 329		

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F 329	Continued From page 37 schizophrenia paranoid, depression, schizoaffective disorder bipolar type with the interventions to administer analgesia per MD order and observe for effectiveness; evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic medications as needed; observe for and report any changes in mood; observe for mental status/mood state changes when new medication is started or with dose changes. - At risk for adverse effects related to use of antipsychotic medication, use of antidepressant medication included interventions to evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs; notify physician and family/significant others of changes in behaviors; observe mood state/behavior; observe for effect of dosage change and notify physician of any decline ADL ability or mood/behavior. - Cardiac [heart] disease related to hyperlipidemia and hypotension included the intervention to administer medication as per MD orders and observe for effectiveness. a. Psychotropic Medications May, 2016 - Admission to facility with multiple diagnoses including paranoid schizophrenia and bipolar schizoaffective disorder. 5/15/17 - Physicians' orders included an antipsychotic medication for bipolar schizoaffective disorder. July, 2017 - October, 2017 - Behavior monitoring for the antipsychotic was to assess for mood changes. This behavior did not incorporate the behaviors associated with the diagnosis of	F 329		

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	085020	A. BUILDING _____ B. WING _____	10/17/2017

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F 329	Continued From page 38 paranoid schizophrenia. During an interview with E5 (UM) on 10/13/17 at 9:08 AM E5 confirmed that behavior monitoring for the antipsychotic only included mood changes. The specific behaviors R92 had experienced with the two types of schizophrenia were not included. b. Blood Pressure Medications Physicians' orders for vital sign monitoring and Midodrine, a drug to help increase blood pressure: - 5/15/17: Take vital signs every shift. - 5/30/17: Give three times a day PRN for systolic BP under 90. - 9/25/17: Give three times a day for hypotension (no BP parameter). - 9/27/17: Give three times a day and hold if systolic BP greater than 100. July, 2017 - October, 2017 - Review of vital signs, eMAR and nursing notes found 20 administrations given or held without meeting the ordered parameter: - Not administered when BP below ordered parameter or BP not assessed: July 4, (night), 17 (day); August 17 (day); October 1 (10 PM), 3 (6 AM, 2 PM), 4 (6 AM) 5 (10 PM), 8 (6 AM, 2 PM), 9 (6 AM, 2 PM), - Administered when BP above ordered parameter or BP not assessed: October 1 (6 AM), 2 (6 AM, 2 PM, 10 PM), 4 (10 PM), 7 (10 PM), 9 (10 PM), 10 (10 PM). During an interview with E5 (UM) on 10/11/17 at 2:28 PM confirmed that multiple doses of the medication were either given or held in error. E5 stated that usually blood pressure medications	F 329		

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F 329	Continued From page 39 are held if under a designated number, and this was ordered to be held when over the parameter. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 10/17/17 at 2:00 PM.	F 329		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 356		12/15/17

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F 356	Continued From page 40 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to ensure daily posting of facility staffing. Findings include: 10/9/17 8:15 AM - upon arrival to facility Federal staff posting was from Friday 10/6/17. 10/16/17 9:37 AM - Federal staff posting was from 10/13/17. 10/16/17 3:28 PM - spoke with E1 (NHA) about Federal posting, stated the receptionist is suppose to post each day. Made aware that it was not posted the past two weekends. 10/17/17 9:00 AM - Monday 10/16 posting still in lobby. 10/17/17 11:45 AM - Monday's [10/16/17] staffing is still posted in lobby.	F 356	A. There were no residents identified by this deficient practice and no corrected action can be taken. B. There was no negative outcome from this deficient practice. Staff postings are now prominently displayed daily in in the lobby and readily accessible to the residents and visitors. C. The scheduler or designee will calculate and post the nursing hours per shift daily. The weekend reception staff will prepare and post the weekend staffing schedules. D. Daily audits will be conducted monthly x1 and the weekly X8 and 100% compliance is achieved X3. The audit findings will be reported to the QAC monthly X 3.	

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F 356	Continued From page 41 These findings were reviewed with E1, E2 (DON) and E3 (ADON) at the exit conference on 10/17/17 at 2:00 PM.	F 356		
F 362 SS=E	483.60(a)(3)(b) SUFFICIENT DIETARY SUPPORT PERSONNEL (a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. (b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on interview and observation it was determined that the facility failed to provide sufficient dietary staff on several occasions over the last month closing the main dining room and delaying meal service to the residents. Findings include: During an interview with R100 (Resident Council President) on 10/10/17 around 9:45 AM R100 stated that the "dining room was not open all the time since they are short on staff. They just don't show up, they are always short on weekends. Come Friday, we know what's going to happen over the weekend." Residents "sat in line at the dining room" for a while, then someone finally "told us it was closed." 10/16/17 from 12:00 to 1:15 lunch service on Seaside. The following was observed:	F 362	A. There is no corrective action that can be taken for this deficient practice for residents R100, R122 R89, R161. B. A resident council meeting was held on 11/02/17. No additional concerns regarding this deficient practice were brought to the attention of R122 (Resident Council President) nor to the NHA in attendance. No additional residents were identified at this time. C. All open dietary positions have been filled. There are no current vacancies. The closure of the dining room cannot occur without the approval of the NHA/DON and for valid reasons only. Prior to closure of the dining room, an overhead speaker announcement will be made to the residents at least 2 hours in advance that the dining room will be closed. Trays on the carts will be organized by the kitchen staff by the units	12/15/17

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F 362	Continued From page 42 10/16/17 12:10 PM R122 came out to the dining area on 3 occasions over an 1 hour looking for his meal tray. He received the tray at 1:00PM. During an interview on 10/16/17 at 12:49 PM E22 (CNA) revealed that the Seaside dining room was full the facility could only have 2 more residents in the dining room because the main dining area was closed for the day. E22 said they did have a kitchen and another dining area on the other side that could accommodate all the residents. During an interview on 10/16/17 at 1:00 PM E8 (FSD) revealed that there was not have enough staff to have the main dining area open that day. During an interview on 10/17/17 at 11:10 AM E8 revealed that the dining room had been closed 8 times in the last month. E8 revealed that 7 staff left in the beginning of September. E8 is in the process of hiring staff to fill vacancies. 10/17/17 at 11:30 AM - (R89) confirmed that the main dining room had been closed a few times this month. R89 would eat lunch in the room when the main dining was closed. R89 disclosed the wait was typically an hour different from eating in the main dining room. Also, R89 revealed that they are notified when they arrive to the main dining room. 10/17/17 at 1:00 PM - (R161) confirmed that the main dining room had been closed a few times and that R161 ate in her room usually about an hour or so later than if they eat in main dining room. R161 revealed they are not notified until we get to the main dining room.	F 362	and room numbers to prevent a delay in room service to the residents. D. The FSD (E8) or designee will audit the number of closure requests monthly x6 months. If requests exceed 1 per month a review will be completed of dietary staffing and additional provisions will be put in place to ensure dining staff have additional supports to keep the dining room open. The audit findings will be reported to the QAC monthly X6.	

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F 362	Continued From page 43 10/17/17 at 1:05 PM - (R122) confirmed the main dining had been closed more than 6 times in the last month. R122 eats in the room and was notified after waiting outside the door of the main dining room. R122 thought they could have made an announcement to say the main dining was closed and there would be a delay. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 10/17/17 at 2:00 PM.	F 362		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.	F 371		12/15/17

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F 371	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to serve food under sanitary conditions. Findings include: 1. During the lunch dining observation in the main dining room on 10/9/17: At 11:26 AM, E17 (Rehab Technician) picked up silverware that a resident dropped on the floor and did not wash her hands or use hand sanitizer afterwards. E17 then served drinks and passed out plates to residents. 2. Dining observation on 10/9/17 between 11:30 AM - 11:48 AM of meal tray delivery to Sierra unit rooms: - E13 (CNA) assisted another staff member to pull up a resident in bed, then obtain a meal tray from the cart and delivered it to room 129 without performing hand hygiene. Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference on 10/17/17 at 2:00 PM.	F 371	A. No corrective measures can be taken for this deficient practice. E17 and E13 were immediately educated regarding proper food handling and infection control preventions. B. No other residents were identified as being affected by this deficient practice. C. All staff will be educated on proper food handling, infection control preventions including handwashing as per facility policy and procedures. D. Observational audits will be completed during meal passes weekly X4 then monthly X2 until 100% compliance is achieved X3. The audit findings will be reported to the QAC monthly X3.	
F 406 SS=D	483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-	F 406		12/15/17

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F 406	Continued From page 45 (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide the specialized services according to the PASRR Level II evaluation for one (R139) out of 40 sampled residents. Findings include: Review of R139's clinical record revealed: 12/16/16- R139's PASRR Level II Determination of Mental Illness Recommendation documented that R139 required specialized services. The recommended services included that supportive counseling was to be offered and provided by a licensed mental health provider. 12/17/16- A patient referral for supportive counseling was completed by E20 (Social Services Director) and stated under additional comments that R139 could not participate in counseling sessions due to impaired cognition. There was no evidence that the PASRR unit was notified. 3/13/17- R139's PASRR Level II Determination of Mental Illness Recommendation documented that R139 required specialized services. The recommended services included that supportive counseling was to be offered and provided by a licensed mental health provider. There was no	F 406	A. The PASRR unit was informed on 05/24/17 by an acute psychiatric facility of R139's inability to participate in the recommendation for specialized services due to a severe cognitive deficit. No specialized services are recommended at this time for R139. B. A full audit was completed on all Level II PASRR's within the facility. There were no other identified deficient practices. C. The social services director and social services assistant were educated by the corporate social services consultant regarding proper notification requirements by the PASSR unit. D. The social services director or designee will audit all new residents that admits to the facility with a Level II PASRR with special services weekly x 4 then monthly x2 and until 100% compliance has been achieved x3. Residents that cannot participate in the recommended specialized service(s) the PASRR unit will be notified timely. The audit findings will be reported to the QAC monthly X3	

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F 406	Continued From page 46 evidence that R139 received supportive counseling or that the PASRR unit was notified that R139 was unable to participate in counseling sessions. 10/17/17- During an email interview at 8:26 AM with M1 (Nursing Supervisor-PASRR unit), it was confirmed that the PASRR unit was not notified that R139 was unable to participate in supportive counseling. M1 stated that on 12/16/16 and 3/13/17, when the supportive counseling was determined a specialized service for R139, the facility should have implemented it. M1 stated that if at any time the counselor felt R139 was unable to benefit from counseling the facility should have documented evidence and made the PASRR unit aware of this decision. 10/17/17- During an interview with E20 at 10:00 AM it was again confirmed that the PASRR unit was not notified that R139 was unable to participate in supportive counseling. E20 stated that she only spoke with the counselor about R139 not being a candidate for counseling, and that the counselor did not put it in writing. E20 stated that she realized that the process was completed incorrectly and the PASRR unit should have been notified. Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference on 10/17/17 at approximately 2:00 PM.	F 406		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.	F 441		12/15/17

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F 441	Continued From page 47 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 441		

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F 441	Continued From page 48 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview it has been determined that the facility failed to implement and maintain an effective infection control program by not obtaining current Tuberculosis x-rays or annual Tuberculosis assessments for three (E26, E30 and E31) out of 25 sampled employees. Findings include: E26 (LPN) started working in the facility on 9/13/17. E26's chest x-ray was completed on 1/27/15 and an annual assessment was completed 9/13/17. No assessment was received for 2016 nor was a current x-ray obtained.	F 441	A. No residents were affected by this deficient practice. E26, E30 and E31 received new chest x-rays to verify any active disease. All results were negative. B. Because all residents are potentially affected by this deficient practice, an audit was completed on all employees with a record of chest x-rays. Those with a no sign and symptoms record from 1 year of date of x-ray were sent for a new chest x-ray to confirm no active disease. C. All new hired employees presenting with chest x-rays will be screened to ensure that they meet the recommendations of the Centers for	

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F 441	Continued From page 49 E30 (CNA) stared working in the facility on 10/9/17. E30's chest x-ray was completed on 8/26/15 and an annual assessment was completed 10/10/17. No assessment was received for 2016 nor was a current x-ray obtained. E31 (CNA) started working in the facility on 10/9/17. E31's chest x-ray was completed on 9/23/13 and an annual assessment was completed 10/10/17. No assessments were received for 2014, 2015 or 2016 nor was a current x-ray obtained. The Centers for Disease Control recommends that all health care workers working in long term care facilities be tested upon hire. Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference on 10/17/17 at approximately 2:00 PM.	F 441	Disease Control (CDC) including annual assessment(s) subsequent to the date of chest x-ray. D. The Infection Control/Staff Development nurse or designee will audit all new hires for 6 months with chest x-ray and annual assessment to ensure CDC are followed. The audit findings will be reported to the QAC monthly x6.	
F 469 SS=F	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it has been determined that the facility failed to maintain an effective pest control program. Findings include: January - September 2017 - Review of the contracted pest control company's service records revealed a total of 254 out of 486 stations/rooms being scheduled, but skipped over	F 469	A. There was no adverse outcome from the identification of insects in the noted areas. No residents were directly affected or identified by this deficient practice. The facility was subsequently treated by the contracted pest control service for insects and resolved. B. Because all residents have the potential to be affected by this deficient	12/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	10/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

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F 469	Continued From page 50 the course of the nine monthly visits, the insect light trap in the kitchen being observed unplugged each month (including months the kitchen area is marked as "skipped") and in the services provided section nine out of nine months the "sales floor" is mentioned as being inspected. 9/21/17 - Review of maintenance records revealed that crawling insects were seen in the Seaside dining room and near the nurse's station. The facility treated this area the same day. 10/9/17 8:30 -9:00 AM - flies observed in Seaside dining room around residents and their food 10/9/17 11:33 AM - fly observed in room 329 10/9/17 12:10 PM - flies observed around residents and aides and trays in Sierra dining room 10/9/17 12:30 PM - fly and crawling insect observed in Seaside dining room 10/9/17 11:56 AM - flies observed around plates of food 10/10/17 1:54 PM - flies observed in room 134 10/11/17 9:00 AM - gnat observed in Sierra dining room 10/11/17 9:00 AM - cricket and 2 flies observed in Seaside dining room 10/12/17 2:14 PM - flies observed in Seaside dining room 10/13/17 4:25 AM - 12 large crawling insects	F 469	practice, a facility wide audit for insects was completed of resident rooms and all common areas. Any identified areas with noted insects were immediately treated and resolved. C. A new Pest Control Management service has been implemented. The pest control service is required to visit the facility every 2 weeks and do a facility wide inspection to identify and manage pest issues. Pest Control Reports will be generated to the Director of Maintenance for review to ensure the entire facility is inspected every other week and free of insects. D. Daily audits will be completed x 1 month then weekly x 2 months and 100% compliance is achieved x3. Audit findings will be reported to the QAC monthly x 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 469	Continued From page 51 observed on Seaside unit, in dining room and hallway, dead and alive 1013/17 4:35 AM - four large crawling insects observed in Sierra hallways 10/13/17 5:30 AM - large crawling insects observed earlier this morning on Seaside and Sierra, alive and dead, were still in these areas 10/16/17 11:30 AM - gnat in the dry food storage area, 5 flies in the kitchen, and fly in the hallway outside of the kitchen. During an interview at the same time, E8 (FSD) confirmed that there has been an issue with flies and gnats in the kitchen and that maintenance was aware and the pest control company was addressing the issue. 10/16/17 - During an interview at 12:31 PM, E7 (FMD) explained that the manager of the pest control company has been contacted to express the maintenance department's concern with inaccurate service records. Concerns include the insect light trap in the kitchen was unplugged one month, and it continues to appear on each report and each month the pest control technician is escorted to all areas stations/rooms. No areas are skipped. It is unclear why the pest control program is not effective if all rooms are being treated regularly and equipment is being maintained. 10/16/17 12:20 PM - two large crawling insects observed in Seaside hallway between dining room and nurse's station 10/17/17 1:00 PM - large crawling insect	F 469		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 469	Continued From page 52 observed in the connecting hallway between Sierra and Seaside Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference on 10/17/17 at approximately 2:00 PM.	F 469		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Pinnacle Rehab & Health Center DATE SURVEY COMPLETED: October 17, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from October 9, 2017 through October 17, 2017. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 144. The stage two survey sample was forty (40).	The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable law. The facility has achieved substantial compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements.	12/15/17
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed on October 17, 2017: F174, F241, F242, F244, F257, F258, F276, F279, F280, F329, F356, F362, F371, F406, F441, and F469.	Cross reference POC for 2567L survey completed 10/17/17 for F-tags: F174,F241, F242, F244, F257, F258, F276, F279, F280, F329, F356, F362, F371, F406, F441, and F469.	

Provider's Signature _____ Title Administrator Date 11/07/17